AACP Guidelines for Recovery Oriented Services

Introduction

Behavioral health problems and services have been viewed variably by those giving and receiving the services. Many have considered those delivering the services as autocratic and paternalistic. Professional helpers have viewed those with mental illness as disabled and they have been oriented to care for such people as individuals with perpetual needs. From this perspective, they have assumed positions of power in the relationships they have shared with consumers. In most service systems, programs are developed to meet the needs of a prototypical patient. Program elements are often rigidly defined to attend to that prototype. Consumers have been expected to fit into these services, whether they match their needs precisely, or not. The assumption that one size can fit all has not been a successful approach to service planning.

Professionals have been trained to think in terms of chronic, unremitting or even deteriorating disabilities in their patients with severe mental illness. Even in the addiction field, where many recovery concepts originated, the professional culture has generally maintained an authoritarian posture. Little hope has been offered for a return to a productive, respected place in the community, outside of highly prescriptive and restrictive parameters. Service users have reported feeling humiliated, demeaned, and devalued by their experiences within these systems. Some have developed profound hostility and mistrust towards the systems that were meant to help them. This has frequently left service users confused and alienated, cut off from hope and meaning in their lives.

Today many consumers of behavioral health services have adopted recovery perspectives. These concepts have been used in some quarters for many years, but interest in them has become widespread relatively recently. Although recovery has been variably defined, most conceptualizations recognize that recovery is a highly personal process and one that continues throughout a person's life. Most definitions include several elements from the list below:

- hope and faith
- self-management and autonomy
- restoration and personal growth
- tolerance and forgiveness
- adaptability and capacity to change
- personal responsibility and productivity
- peer support and community life
- dignity and self-respect
- acceptance and self awareness
- universal applicability

The emergence of recovery models have occurred, in part, through the organizations and advocacy developed in the consumer movement. Part of this new perspective on the course of behavioral health disorders has been a re-examination of the relationship

between the user of services, the service system, and the professionals working in that system. This has stimulated service systems and professionals to examine themselves and to consider how they can best meet the emerging needs of persons who require services. The transformation of systems from a paternalistic illness oriented perspective to collaborative autonomy enhancing approaches represents a major cultural shift in service delivery.

These guidelines are intended to facilitate the transformation to recovery-oriented services and to provide direction to organizations or systems that are engaged in this process. They should be useful to systems that have already made significant progress in creating services that promote recovery by providing a systematic way of thinking about quality improvement and management for these services**.** The guidelines are organized divided into three domains of service systems: administration, treatment and supports. Each domain is composed of several elements and recovery-enhancing characteristics for each of these elements are described. Some suggestions for measurement of achievement/progress in each of these areas are included.

Recovery Oriented Services Quality Domains

ADMINISTRATION

Mission and Vision - Strategic Plan

Commitment to processes fostering recovery must be clearly articulated for organizations to successfully pursue and maintain recovery-oriented services (ROS). The organizational mission should commit to the vision that individuals with mental illness can reorient their lives to a recovery process. Professionals must articulate the goal of developing and strengthening the community of recovering persons. Strategic planning will include a focus on achieving the mission of strengthening the community of recovering persons.

Indicators:

A) Development of mission and vision statements articulating organizational commitment to recovery and a process for achieving recovery oriented services.
B) Organizational review and strategic planning process that incorporates diverse viewpoints from the community of service users.

Organizational Resources

Organizational structures responsible for oversight of recovery oriented services must be empowered and supported through the highest levels of the organization to create a political environment that is conducive to the development of these services. This should be manifest at least in part, through the provision of adequate financial resources to meet the requirements of such programming. This would include funding to ensure ample

consumer participation in administrative processes governing the organization (i.e., by providing appropriate compensation for their expert contributions) and to create employment opportunities for consumers to enhance ROS.

Indicators:

A) Annual budget insures adequate resources to support consumer participation in administrative processes.
B) Significant representation of persons in recovery on organization's treatment and support staff.

Training- Continuing Education

Adequate understanding of recovery concepts, and of consumer perspectives and aspirations, by professionals working in service delivery systems is essential to the implementation of ROS. Ensuring that professionals have adequate exposure to consumers in non-clinical settings should be a significant goal of orientation, training, and continuing education programming. Professionals must have exposure to recovery models in their Continuing Education programs. Training standards and competency requirements should reflect this value.

Indicators:

A) Processes developed for interactions and/or communications between consumer and providers in non-clinical settings.
B) Establishment of core competency standards regarding knowledge of recovery principles.

Continuous Quality Improvement

CQI programming assumes that those most intimately involved with the activities and services of the organization are in the best position to identify improvement opportunities and to develop and evaluate plans to take advantage of them. ROS providers that incorporate users of services into the governance of their agency/organization will naturally integrate consumers into quality improvement processes at all levels. Consumer involvement in CQI projects as equal partners should be supported through adequate compensation of consumer participants for the services they provide, just as it is for professional participants. This approach provides an important way to empower individuals and to foster investment in the services they receive by recognizing the value of collaboration in establishing stable recovery environments.

Indicators:

A) Processes in place to ensure that consumers are included in CQI activities as equal partners with professionals.
B) Agency budgets will reflect compensation for consumer involvement in CQI activities.

Outcome Assessment

As behavioral health services become more accountable to the outcomes they produce, recovery oriented services will develop indicators that relate not only to concrete levels of function, but also to variables related to an individual's progress in recovery and personal growth. These somewhat qualitative and often abstract aspects of experience should be translated into quantifiable and measurable constructs that will provide evidence for quality of life as a valid aspect of service outcome.

Indicators:

A) Outcome indicators will include items related to quality of life, recovery and self fulfilling function.
B) Identification and use of standardized quantification scales for recovery elements
C) Established process for consumer participation in developing outcome indicators for progress in recovery.
D) Outcome measurement processes are used to improve services and programs

TREATMENT

Service Arrays

A variety of services that support consumer self-sufficiency and decision-making should be available in comprehensive service systems. Available services should include flexible options for individual and group psychotherapy, rehabilitation and skills building opportunities, various intensities of empowering case management, crisis management and hospital diversion plans, participatory psychiatric medication management. Prevention, health maintenance, and disease self-management principles should provide the guiding philosophy for all clinical services.

Indicators:

A) Integration of consumer, family and peer supports, disease management education and crisis management planning will be reflected in policy and procedure documents.
B) Establishment of services supportive of recovery processes and which incorporate self management principles
C) Recovery oriented service design will be reflected in policy and procedure documents, including financial structures that encourage such service development

D) Consumers and family members are enlisted to participate in the decisions regarding resource allocation and service development.

Advance Directives

Encouraging and facilitating the completion and utilization of advance directives by service users is an important process in creating a recovery-oriented environment. Advance directives provide a method to respect the wishes of consumers should they become incapacitated at some future time. Providing adequate information for consumers to make informed decisions when they are capable of doing so is a critical aspect of the process.

Indicators:

A) Established process for obtaining informed advance directives from consumers during periods of relatively healthy function.
B) Established process for review of advance directives during periods of relapse/incapacitation.

Cultural Competence

Culturally sensitive treatment and services indicate respect for individuals and recognition that beliefs and customs are diverse and impact the outcomes of recovery efforts. Access to service providers with similar cultural backgrounds and communication skills, supports consumer empowerment, autonomy, self-respect, and community integration.

Indicators:

A) Development of treatment staff with an ethnic/racial profile representative of the community being served
B) Established cultural competency standards for organization's staff.

Planning Processes

Respect for consumer participation and efforts to obtain meaningful input from them will be a hallmark for ROS. This input should be solicited even when consumers are most debilitated and opportunities to make choices should be provided whenever possible. ROS will emphasize consumer choice in all types of planning processes including, but not limited to treatment, service, transition and recovery plans**.** ROS will emphasize the identification and use of a person's strengths to design a plan to overcome their difficulties.

Indicators:

A) Development of collaborative process for developing continuous comprehensive service plans between consumers and providers.
B) Efforts to engage more impaired clients are reflected in agency planning records
C) Process in place to inform consumers of treatment/service options and to discuss pros and cons of each prior to service plan development.

Integration - Addiction-MH

ROS will value and promote holistic approaches to health maintenance and recovery development that recognize the impact and interaction of co-occurring illnesses and the need to address them concurrently. Principles of recovery can be applied to diverse processes that disrupt health and can provide a common thread by which the return to health may be orchestrated.

Indicators:

A) Integration of mental health and substance abuse programming is reflected in agency activities.
B) Establishment of recovery principles as unifying concepts in provision of holistic mental health, physical health and addiction services.
C) The presence of co-occurring substance and mental health disorders is reliably detected through screening processes.
D) Development of well coordinated referral procedures to collaborative agencies for effective parallel treatment of co-occurring disorders. (If integrated services are not available.)

Coercive Treatment

The use of coercive measures for treatment is not compatible with recovery principles. Therefore, providers of ROS will make every effort to minimize or eliminate the use of coercive treatments to the greatest extent possible. When they are unavoidable, they should be used with great care and circumspection. Involuntary treatment arrangements should occur in the least restrictive environments possible to meet the needs of disabled individuals and maintained for the shortest period of time possible. Individuals must be treated with compassion and respect during episodes of incapacitation and should be offered choices to the greatest extent possible with regard to their treatment plan. Attempts to transition to voluntary treatment status should be strongly encouraged to assure that recovery principles might be restored to treatment processes.

Indicators:

A) Appointment of consumer advocacy liaisons to courts and involuntary treatment authorities
B) Development of strategies to engage and empower clients on involuntary status that are incorporated into treatment plans and agency programming.
C) Demonstration of reduction in the use of coerced treatment options over defined periods.

Seclusion and Restraint

The use of seclusion and restraint should be used only in extreme situations where safety is threatened. When necessary, it should be kept to a minimum and should be implemented in the most humane manner possible. The use of simultaneous seclusion and restraint should never be used, and processes to assure that these measures are discontinued as soon as possible should be developed. Debriefing for all individuals involved in the incident should be required, and effective quality monitoring and improvement processes should be in place.

Indicators:

A) Development of crisis plans employing progression of interventions designed to deescalate volatile situations
B) Constraint of individuals who are presenting clear threats to their own or other's safety and welfare are guided by both individualized plans and agency policy.
C) Debriefing occurs after all incidents requiring restraint or seclusion.
D) All staff potentially able to respond to a volatile incident are trained in de-escalating techniques and alternatives to forceful constraint.

SUPPORTS

Advocacy and Mutual Support

Facilitation of contact with and participation in consumer advocacy groups and mutual support programs is an important aspect of ROS. Liaison with entities involved in these activities should be established to enable this process. Intensive community based peer mentoring/sponsorship programs, consumer managed peer support networks and drop-in centers are examples of these services.

Indicators:

A) Active facilitation of participation of clients in advocacy organizations is demonstrated.

B) An agency liaison with local advocacy and support groups is identified and active.
C) Majority of consumers participate in peer support activities.

Access Facilitating Processes

Development of resources available to improve access to services should include, but should not be limited to communication aids (language accommodation), child care, transportation, mobile services and pharmacy, collaborative relationships with primary care providers, and an ombudsperson to address other barriers to access.

Indicators:

A) Agency records will reflect liaisons with agencies providing access related services
B) Effective processes in place to obtain services for persons who are not adequately insured or otherwise unable to access existing services financially.
C) Completion of access analysis identifying systemic barriers to receiving services
D) Service users report satisfaction with their access to services they have chosen.

Family Services

Family education and empowerment activities supportive of recovery principles will strengthen attempts by consumers to establish recovery and should be developed by providers of recovery-oriented services. By broadening family members' understanding of recovery processes and their role in fostering autonomy and growth in disabled loved ones**,** they can be engaged to develop coping skills and to become active supports to a consumer's efforts to enter and maintain recovery.

Indicators:

A) Family involvement in agencies will be reflected in educational, social and advocacy programming by the agency.
B) Liaison and collaboration with advocacy groups will be reflected in family oriented programming.
C) Incorporation of family participants in treatment team and planning processes (when desired by consumer)
D) Family psycho-education provided for all SPMI clients with some family involvement

Employment and Education

A full array of training, education and employment opportunities should be available to consumers who wish to broaden their experience and independence. Developing skills and putting them to use is often one of the most self-affirming and confidence enhancing activities that recovering persons can engage in. ROS will support the aspirations of

consumers and guide them to processes for achieving them rather than dismissing such aspirations as unrealistic.

A) Development of a substantial array of employment and training opportunities with various levels of support for these activities
B) Consumers experience support for their vocational choices and assistance in pursuing them.
C) Process for vocational counseling and support is integrated with other aspects of the recovery process
D) Individualized placement and support is predominant approach to vocational rehabilitation.

Housing

A full array of independent living and supported housing options should be available to consumers and efforts should be made to support the consumer's preferences regarding their living situation. Housing which is tolerant of autonomous behaviors and which makes few demands upon residents should be available, including housing that is tolerant of poorly controlled substance use.

A) Consumers express satisfaction with available housing options
B) Consumers feel that their housing preferences are respected and accommodated to the greatest extent possible.
C) A full array of housing options are available including various tolerant housing options
D) All housing options support independence, choice and progression.

Summary

The establishment of recovery-oriented services will require a transformation of the way professionals have been trained to think about their roles. This re-conceptualization will include an understanding that the helper's role should be facilitative rather than directive, hope inspiring rather than discouraging, respectful rather than paternalistic, and collaborative rather than autocratic. Recovery oriented services will enhance the capacity for every individual to reach their full potential. These guidelines can be used by organizations to assess their own progress in establishing ROS and to begin the process of establishing measurable indicators for quality monitoring. They will also be useful to larger systems and regulatory agencies in developing standards and establishing accountability. They should be useful to consumer advocacy groups in their attempts to transform stagnant systems of care.

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